COMMONWEALTH of VIRGINIA

ALISON G. LAND, FACHE
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
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www.dbhds.virginia.gov

Tuesday, January 5, 2021

The Honorable Mark D. Sickles, Chair
House Health, Welfare, and Institutions Committee
Pocahontas Building
900 East Main Street
Richmond, VA 23219

Dear Delegate Sickles:

Chapter 918 of the 2020 Acts of Assembly (HB 1699 and SB 768) directs the Department of Behavioral Health and Developmental Services (DBHDS), in conjunction with several other state agencies and stakeholders, to review the current process for conducting temporary detention order (TDO) evaluations and to develop a comprehensive plan to expand those who may conduct evaluations. The language states:

> *That the Commissioner of Behavioral Health and Developmental Services shall establish a work group to (i) review the current process for conducting evaluations of persons who are subject to emergency custody orders to determine whether they meet the criteria for temporary detention, including any challenges or barriers to timely completion of such evaluations and factors giving rise to delays in completion of such evaluations, and (ii) develop a comprehensive plan to expand the individuals who may conduct effective evaluations of persons who are subject to emergency custody orders to determine whether they meet the criteria for temporary detention. The work group shall consider other states' experiences in expanding the individuals who may conduct evaluations of persons subject to emergency custody orders. Such comprehensive plan shall include specific recommendations for legislative or budget actions necessary to implement the plan. The work group shall include representatives of the Virginia Association of Community Services Boards, the National Alliance on Mental Illness - Virginia, the Virginia Organization of Consumers Asserting Leadership (VOCAL), the Psychiatric Society of Virginia, the Virginia College of Emergency Physicians, the Medical Society of Virginia, and such other stakeholders as the Commissioner may deem appropriate. The work group shall report its findings and conclusions and the comprehensive plan to the Governor and the Chairmen of the House Committee on Health, Welfare and Institutions, the Senate Committee on Education and Health, and the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century by December 1, 2020.*

In accordance with these items, please find enclosed the combined report for Chapter 918 of the 2020 Acts of Assembly. Staff are available should you wish to discuss this request.

Sincerely,

Alison G. Land, FACHE

Commissioner, Department of Behavioral Health & Developmental Services

CC:
Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

COMMONWEALTH of VIRGINIA

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Tuesday, January 5, 2021

The Honorable L. Louise Lucas, Chair
Senate Education and Health Committee
Pocahontas Building
900 East Main Street
Richmond, VA 23219

Dear Senator Lucas:

Chapter 918 of the 2020 Acts of Assembly (HB 1699 and SB 768) directs the Department of Behavioral Health and Developmental Services (DBHDS), in conjunction with several other state agencies and stakeholders, to review the current process for conducting temporary detention order (TDO) evaluations and to develop a comprehensive plan to expand those who may conduct evaluations. The language states:

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Tuesday, January 5, 2021

Governor Ralph Northam
Patrick Henry Building
1111 E Broad Street
Richmond, VA 23219

Dear Governor Northam:

Chapter 918 of the 2020 Acts of Assembly (HB 1699 and SB 768) directs the Department of Behavioral Health and Developmental Services (DBHDS), in conjunction with several other state agencies and stakeholders, to review the current process for conducting temporary detention order (TDO) evaluations and to develop a comprehensive plan to expand those who may conduct evaluations. The language states:

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CC:
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Tuesday, January 5, 2021

The Honorable Creigh Deeds, Chair
Joint Subcommittee to Study Mental Health Services in the Twenty-First Century
900 East Main Street
Richmond, VA 23219

Dear Senator Deeds:

Chapter 918 of the 2020 Acts of Assembly (HB 1699 and SB 768) directs the Department of Behavioral Health and Developmental Services (DBHDS), in conjunction with several other state agencies and stakeholders, to review the current process for conducting temporary detention order (TDO) evaluations and to develop a comprehensive plan to expand those who may conduct evaluations. The language states:

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Alison G. Land, FACHE

Commissioner, Department of Behavioral Health & Developmental Services

CC:
Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

Virginia Department of Behavioral Health & Developmental Services

Report on Chapter 918 of the 2020 Acts of Assembly (HB 1699 and SB 768)

Report on Who Should Conduct TDO Evaluations in Virginia

To the Governor and the Chairmen of the House Committee on Health, Welfare and Institutions, the Senate Committee on Education and Health, and the Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century

Tuesday, January 5, 2021

1220 BANK STREET • P.O. BOX 1797 • RICHMOND, VIRGINIA 23218-1797 PHONE: (804) 786-3921 • FAX: (804) 371-6638 • WEB SITE: WWW.DBHDS.VIRGINIA.GOV

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Executive Summary

Individuals who are subject to an emergency custody order (ECO) are required to be evaluated by a Certified Preadmission Screening Clinician (CPSC) to determine if they meet criteria for a temporary detention order (TDO). Individuals who are not under an ECO, but are believed to require involuntary psychiatric hospitalization, may also be evaluated by a certified CPSC to determine if they meet criteria for a TDO. Under current Virginia code, a TDO cannot be issued until it is determined that a) the individual meets civil commitment criteria and b) a willing treatment facility is identified. Certified CPSCs in Virginia are mental health professionals who are employees or designees of the community services boards (CSB), and are responsible for performing a comprehensive evaluation of a person experiencing a mental health crisis, establishing a preliminary diagnosis, recommending the disposition of the individual – including establishing crisis plans, identifying community resources for outpatient treatment, and identifying a willing treatment facility for inpatient psychiatric treatment – and subsequently, if a TDO is issued, participating in the accompanying legal process. The CPSCs serve as a principal access point to the public mental health system. This has been the established process for more than two decades, with a few changes over the years. This report examines the current process for conducting evaluations and identifying a willing facility; assesses opportunities to expand the workforce that can conduct such evaluations to include other qualified professionals in light of both the vision for where the system is headed and where it is now; explores potential short- and long-term positive and negative impacts associated with possible changes; and recommends necessary legislative changes, funding, and additional resources required to implement any changes.

The TDO Evaluator (HB 1699/SB 768) Workgroup was tasked to:

- Review the current process for conducting evaluations, including any challenges or barriers to timely completion;
- Develop a comprehensive plan to expand the individuals who may conduct Preadmission screenings, and consider other states' experiences; and
- Include specific recommendations for legislative or budget actions necessary to implement the plan.

With extensive input from the workgroup, DBHDS developed comprehensive plans for two potential pathways for expanding who can perform preadmission screenings: 1) new categories of professionals with sufficient experience within the community services board/behavioral health authority system; and 2) physicians and licensed mental health professional (LMHP) emergency department staff. These two pathways are described in more detail within the report. It is important to note that expanding to allow preadmission screenings to be performed by physicians and LMHP emergency department staff would, for the first time in decades, permit a private entity to be a point of entry into the public psychiatric hospital system. The workgroup acknowledged the valuable training and expertise of the professionals who dedicate their careers to working with individuals experiencing a mental health crisis, and so the question of which professions have training and expertise to assess risk should be allowed to conduct preadmission screenings did not render much controversy. Open questions remained, however, around operationalizing the procedural aspects in Virginia Code related to involuntary commitment and the potential or perceived negative consequences of allowing preadmission screenings to be performed by professionals outside of the CSB system. In trying to address these issues, it was acknowledged that the current process is strained. In some cases, this may be due to workforce shortages at CSBs and is also due to inadequacies in the bed finding process, which adds a significant administrative burden in an already cumbersome process.

Involuntary commitment is one of the most complex clinical and legal processes in mental health care. The Substance Abuse and Mental Health Services Administration (SAMHSA) has reported that an apparent shortage of psychiatric beds and other services- primarily community based, early intervention

services- in many areas has created a situation in which involuntary commitment may be seen as a way to prioritize intensive mental health services for individuals who would have difficulty accessing services otherwise, or for situations where a lack of access to comprehensive community services obligate an overreliance on high cost, high acuity services like inpatient hospitalization. Constraints on access greatly influence involuntary commitment practice and policy.[1] Virginia has experienced this firsthand as the state mental health hospitals frequently operate at or above capacity throughout the year. This continues to drive resources towards hospital operations, instead of into the community where comprehensive, high quality, evidence-based outpatient services are sorely needed. The community behavioral health workforce is also depleted, not only because there are not enough licensed mental health professionals and other mental health professionals, but also because the reimbursement for services in lower levels of care is not sufficient compared to compensation in acute inpatient care and even lines of work outside of healthcare.

Lastly, the workgroup agreed that expanding the categories of professionals who can conduct preadmission screenings would not solve all of the challenges with the screening process, including lack of consistent quality monitoring, consideration of the patient experience, and time-consuming administrative aspects such as the bed search process. Recommendations were developed to identify opportunities for improvements across the overall behavioral health system of care.

Recommendations

Recommendation #1: Prioritize and continue the development of a comprehensive system of care, through STEP-VA and Medicaid Behavioral Health Enhancement in Virginia. This continuum of care across the lifespan should focus on high quality, evidence-based community services to prevent the need for more costly acute care and reduce overreliance on institutional care. There is a critical shortage of licensed behavioral health workforce and all professionals with the skills, training, and knowledge in various aspects of the evaluation and treatment of mental illness should be employed to their fullest potential, work collaboratively with each other, and optimize resources across the system. While workforce shortages are an issue regardless of payor source, they are magnified in the Medicaid population because many licensed health professionals accept few or no Medicaid members due to low Medicaid reimbursement rates. Thus Medicaid Behavioral Health Enhancement is a critical strategy to build workforce capacity to deliver high quality services, particularly those to prevent the need for mostly costly acute care and reduce overreliance on institutional care.

Recommendation #2: Integrate principles of continuous quality improvement to ensure that any implemented system changes are standardized, monitored, and periodically revised as needed. Quality management processes should be included in a plan for any system changes. Quality oversight across a public and private system may benefit from a broad data management and integrated care coordination process and should include the healthcare triple aim:

- Improve the patient experience: regardless of who conducts the preadmission screening, in order to help ease any resulting trauma, requirements should be considered to have peer support specialists present during the evaluation.
- Improve health outcomes: optimizing and expanding the behavioral health workforce facilitates people accessing other needed services.
- Improve cost efficiency: promote emergency room avoidance and diversion from inpatient services when appropriate.

[1] Substance Abuse and Mental Health Services Administration: Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice. Rockville, MD: Office of the Chief Medical Officer, Substance Abuse and Mental Health Services Administration, 2019.

Recommendation #3: Current processes, such as completion of TDO-related paperwork and bed searches, are lengthy and take away from time spent with an individual in crisis in need of support. Therefore, any changes to who may prescreen should be paired with efforts to streamline the administrative elements of the process for all prescreeners.

Recommendation #4: Investment in an enhanced bed registry tool, which was considered by the HB1453/SB739 workgroup, is critical to expediting the bed search process as well as facilitating a potential handoff from private provider to CSB if a private provider were conducting the initial preadmission screening or even requesting a preadmission screening.[2] This would also lower the threshold for information the CSB must provide over the phone to hospitals while in search of a bed, as information could be securely uploaded into the registry and shared with inpatient facilities with available beds.

Recommendation #5: Changes to current processes must give special consideration to the impact on inpatient psychiatric bed capacity, especially the impact to the state mental health hospitals given their frequent operation at or above capacity. Evaluators should demonstrate due diligence in diverting individuals from involuntary inpatient treatment and towards least restrictive settings whenever appropriate.

Recommendation #6: Conflict of interest on the part of the evaluator should be avoided at all times.

[2] RD513 - Acute Psychiatric Bed Registry Workgroup Report – November 6, 2020. Available at: https://rga.lis.virginia.gov/Published/2020/RD513

Preface

Chapter 918 of the 2020 Acts of Assembly (HB 1699 and SB 768) directs the Department of Behavioral Health and Developmental Services (DBHDS), in conjunction with several other state agencies and stakeholders, to review the current process for conducting temporary detention order (TDO) evaluations and to develop a comprehensive plan to expand those who may conduct evaluations. The language states:

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Guiding Principles in the Involuntary Commitment Process

Involuntary civil commitment is a legal intervention by which someone acting in a judicial capacity may order a person with mental illness who meets specified criteria to be confined in a psychiatric hospital. Every state in the country has standards, policies, and procedures for commitment. The behavioral health landscape has evolved over the past several decades, shaped by the discovery of effective treatments for psychiatric conditions, the movement of deinstitutionalization and the building of community mental health services, and the advocacy for awareness of the civil rights of individuals with disabilities, therefore ensuring that involuntary commitment is only utilized as a last resort. As such, the workgroup utilized the following guiding principles adapted from the federal Substance Abuse Mental Health Services Administration (SAMHSA) to ground the discussions and inform policies that may affect Virginia's civil commitment process: [3]

Guiding Principles in the Involuntary Commitment Process

(Adapted from SAMHSA)

- Honor individuals' treatment preferences
- Never issue a temporary detention order when a person is otherwise willing to participate voluntarily in services
- Respect and protect the dignity of the person in every step of the process
- Help the person access care in the least restrictive setting
- Clearly communicate all relevant information with the person
- Balance beneficence and personal autonomy
- Employ due process protections at every level
- Consider a person's history of trauma as part of the assessment
- Ensure all persons involved in the process are free of material conflict of interest
- Carefully consider the purpose of commitment in identifying appropriate services
- Use information from family and friends to help inform care
- Individualize care and practice shared decision-making with the person

Virginia's Current Process for Conducting Preadmission screenings for Individuals under an Emergency Custody Order

All individuals under an emergency custody order (ECO) in Virginia must undergo a preadmission screening, and this process is a complex, multi-stage set of tasks; individuals who are not under an ECO may also undergo a preadmission screening. It is a pivotal point within the larger civil commitment process because if involuntary treatment is recommended and a temporary detention order (TDO) issued, the individual in crisis is deprived of his or her liberty. The significance of the individual's liberty interest prescribes constraints on the health care and legal decisions involved; emergency evaluations must be comprehensive to assure appropriate disposition, but they also must be completed in a timely manner. As a result, a multitude of aims and tasks are concentrated in the brief 8-hour emergency custody period authorized under an ECO.

[3] Substance Abuse and Mental Health Services Administration: Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice. Rockville, MD: Office of the Chief Medical Officer, Substance Abuse and Mental Health Services Administration, 2019.

The preadmission screening process can be divided into six phases which may occur simultaneously, but distinguishing domains of activity is helpful to identify tasks to be included in a comprehensive plan. [4] Key requirements of the six phases are summarized below including approximate amount of time spent on each phase or task.

Phase	Action	Description	Approximate Time Spent within the 8-hr ECO period[5]
1	**Referral – Initiation of the ECO**	There are many different entry points into emergency behavioral health services including routine outpatient services, in a local emergency room, by phone, through law enforcement, or from an inpatient medical unit. Evaluations could be conducted in any of those or other locations.	30 minutes (from issuance of the ECO to initiation of the assessment by the CPSC)
2	**Notification of the CPSC**	When an individual is taken into custody by law enforcement, CSB Certified Preadmission Screening Clinicians (CPSCs) are notified of the execution of an ECO. Each region has protocols for this process to ensure activities are completed within the timeframes required. If the individual is not under an ECO, a CSB may still conduct a preadmission screening upon request.	
3	**Conducting the Assessment** (in-person or through a two-way electronic audio and video communication system)	An emergency assessment is completed as soon as possible after receiving notification of the need. Under the current performance contract between DBHDS and the CSBs, the assessment is required to begin within one hour of being contacted in an urban area and within two hours in a rural area.	55 minutes
4	**Assessment Results & Development of a Plan**	The evaluator will determine the least restrictive treatment needed and will refer the individual for community based services if the criteria for inpatient commitment are not met. If the evaluation was completed outside of a medical environment, the individual may be taken to a local emergency department for medical assessment prior to transport to an inpatient psychiatric facility. The CPSC must then complete a nine-page preadmission screening report form before beginning the process of locating a bed when involuntary inpatient treatment is deemed necessary. Community treatment or voluntary inpatient treatment may also be possible dispositions.	20 minutes
5	**Execution of the Plan**	If the individual meets the criteria for involuntary inpatient hospitalization, the evaluator will complete a number of notifications and then begin a bed search, beginning with community hospitals or crisis	Up to 370 minutes (average 240 minutes)

[4] The process for civil commitment of adults is cited in Virginia Code §§ 37.2-808, 37.2-809, 37.2-809.1, 37.2-810, 37.2-813, 37.2-814, 37.2-815, 37.2-816, and 37.2-1104. For minors, the process is set forth in Virginia Code §§ 16.1-338, 16.1-339.1, 16.1-340, 16.1-340.1, 16.2-341-16.2-345. 5

[5] A follow-up review of Virginia's practice of conducting emergency evaluations for individuals subject to involuntary civil admission. DBHDS. (2016).

		stabilization units. Each of these facilities must be contacted by phone and followed with a fax of the preadmission screening form (PAS form) and any other supporting documentation for the potential willing facility to review and consider. If no other placement can be found, the state hospital will be notified and it will serve as the temporary detention facility. Individuals who do not meet the criteria for temporary detention will be referred to appropriate community services by the CPSC.	
6	**Disposition Completed**	When a facility has been identified, the CPSC then contacts the magistrate to request the issuance of a TDO.	
Post-TDO issuance		A commitment hearing is then held after a sufficient time for evaluation and treatment but no later than 72 hours after the TDO is issued.	Up to 72 hours for adults and 96 hours for minors

Responsibilities of Emergency Services Certified Preadmission Screening Clinicians (CPSC)

Certified Preadmission Screening Clinician (CPSCs) are responsible for a range of duties, beginning upon an initial request for evaluation, and continuing through inpatient placement or referral to appropriate community services:

1. The CSB is first contacted by law enforcement when someone is taken into emergency custody (§ 37.2-808.J). If the individual is not under an ECO, a CSB may still conduct a preadmission screening upon request.
2. After being notified by law enforcement that an individual has been taken into emergency custody, the CPSC must call the state facility for the area so that they are aware that, should a TDO be issued and no alternative facility identified, the individual would be transported to said facility (§ 37.2-809.1).
3. The nine-page preadmission screening form developed in 2017 by Institute of Law, Psychiatry and Public Policy and DBHDS to assess risk following evidence-based practices must be completed through interviews with the individual, treating providers, and family members when appropriate as well as review of medical records and other related information. Additionally, the CPSC must ensure the least restrictive action is taken to meet the individual's needs (§ 37.2-816).[6]
4. The CPSC must determine, prior to the issuance of the temporary detention order, the individual's insurance status (§ 37.2-809.G).
5. The CPSC must also determine the facility of temporary detention and note it on the preadmission screening form. If necessary, he or she may change the facility of temporary detention. In that case, the CPSC must provide written notice to the clerk of the issuing court of the name and address of the alternative facility (§ 37.2-809.E).
6. After completing the evaluation, the CPSC must call the state facility back with information necessary to determine the services an individual will need (§ 37.2-809.1).

[6] Preadmission Form, accessible at: http://www.dbhds.virginia.gov/behavioral-health/mental-health-services/protocols-and-procedures

7. If the individual is ordered to mandatory outpatient treatment, the CPSC must participate in the commitment hearing (§ 37.2-817).
8. If the CPSC recommends that the person should not be subject to a temporary detention order, he or she must take the following steps (§ 37.2-809.L).
    a. Inform the petitioner, the person who initiated emergency custody, if such person is present, and an onsite treating physician of his or her recommendation.
    b. Promptly inform such person who initiated emergency custody that the CSB will facilitate communication between the person and the magistrate if the person disagrees with recommendations of the employee or designee of the CSB who conducted the evaluation and the person who initiated emergency custody so requests
    c. Upon prompt request made by the person who initiated emergency custody, arrange for such person who initiated emergency custody to communicate with the magistrate as soon as is practicable and prior to the expiration of the period of emergency custody.

Current Requirements to Become a CPSC in Virginia

The current certification requirements for CSB Preadmission Screening Clinicians were most recently updated in July of 2016.[7] Certification for CPSCs is based on three elements:

I. Licensure Status or Equivalent

All new hire CPSCs must have an acceptable professional license to participate as a CPSC, or have appropriate educational level attainment with other required standards if they are unlicensed.

- Licensed Professional Counselor (LPC)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Clinical Psychologist (LCP)
- Psychiatric Nurse Practitioner or Psychiatric Clinical Nurse Specialist MD/DO
- Bachelors Prepared Registered Nurse (BSN) with five years of experience
- PH.D. OR PSY. D in clinical or counseling psychology
- The following Master's degrees are deemed to meet these requirements:
    - Master of Social Work (MSW)
    - A clinical degree in counseling from a program accredited by the Council for Accreditation of Counseling and Related Educational Programs [CACREP]
    - Master of Science in Rehabilitation from a CACREP accredited program
    - If a Board Executive Director has evaluated the transcript and experience of a potential Preadmission Screening Clinician with a master's degree other than one listed above that includes appropriate clinical training, a request may be submitted to DBHDS for review and a decision whether this requirement is met.

Any CPSC who does not meet the above educational standards but was hired on or before July 1, 2009 without an interruption in their employment conducting preadmission screening evaluations or if he or she was hired between July 1, 2008 and July 1, 2016 provided they met the educational and other requirements as of July 1, 2008.

II. Completion of an online training modules and experiential components of training

To be certified to conduct emergency evaluations, the candidate must complete requisite online, DBHDS established training modules, which include topics ranging from the role and responsibility of the CPSC, the legal requirements related to Virginia's civil commitment process,

[7] Certification of Preadmission Screening Clinicians. DBHDS. (July 1, 2016)

resources for alternatives to hospitalization, interfacing with magistrates and special justices, the process for securing state facility beds, and other relevant parallel processes such as medical assessment. Then, the individual must complete 40 hours of observation of direct emergency services client or collateral contact conducted by a certified CPSC, conduct at least 3 prescreening evaluations under direct observation by a certified CPSC, and receive attestation by their supervisor that, based upon direct observation, the applicant has reached a minimal acceptable level of clinical competence and procedural knowledge to be certified. Due to the potential safety risks, for a minimum of three months after certification, the newly certified person must consult with a supervisor on any case where he/she intends to recommend a release from an ECO without hospitalization. [8]

III. Approval by the CSB clinical supervisor

The final requirement to become a certified CPSC is approval by the CSB clinical supervisor, who is a licensed mental health professional.

Variance to the Process to Meet Requirements to Become a CPSC

CSBs can request a variance to the requirements detailed above due to hardship. Each variance must be signed by the executive director and approved by DBHDS.

Summary of the Virginia Process

Virginia has a well-established preadmission screening process that is supported in various sections of the Virginia Code and reinforced through policy and procedural documents. The process – which includes a range of requirements from the comprehensive preadmission screening form to the role of the magistrate – is intended to incorporate safeguards to prevent unnecessary involuntary psychiatric commitment. However, it is not clear the extent to which these safeguards are effective as there is no state-level oversight process to examine quality or data on a systematic basis. The state oversight process serves mainly to ensure that Code requirements are met. Supporters of maintaining the evaluation role within the CSB system highlight the rigorous local level oversight and the CSBs' inherent knowledge of the overall behavioral health system of care, including the local level resources and the state's diversion strategies to serve individuals in community settings rather than the state hospitals. Proponents for changing the current system note that the administrative burden on critical CSB emergency services workers do not allow for the optimal use of their time. This administrative burden is often related to prescreening paperwork and to the particularly time-consuming process of identifying the facility of temporary detention. Of the eight hour ECO custody period, reportedly, on average, only one hour is actually spent with the person in crisis. In a system with limited skilled mental health providers, this type of expertise would be better utilized in direct patient care. When the preadmission screening evaluation is conducted in emergency rooms, there is often tension between the hospital physician responsible for determining the patient's disposition as the treating hospital physician and the CSB preadmission screener responsible for recommending the patient's disposition in the civil commitment process. While it is generally recognized that many other health professionals are trained to conduct emergency assessments by nature of their profession – such as physicians, psychologists, and other licensed mental health professionals – the CPSC's unique and primary role in the process includes utilizing community resources to explore less restrictive options to mitigate risk and the application of the mental health laws in Virginia. To this extent, CSPCs are the most experienced in Virginia in navigating this clinic-legal interface.

[8] In Virginia, preadmission screening clinicians must complete a certification program approved by DBHDS per § 37.2-809.

Evaluators for Involuntary Commitment in Other States

There is significant variation across states in both the process for involuntary civil commitment as well as the requirements for those professionals who can conduct evaluations for temporary detention. Physicians are the most commonly cited permissible evaluator, followed by mental health professionals (a broad term that includes many of the specified professionals), facility directors, and psychologists. States use either a one or two-person evaluator system, meaning that when temporary detention is recommended a second person with the appropriate credentials, either serves as a witness or an evaluator. The majority of states utilize a one person evaluator for temporary detention, similar to Virginia.[9]

Tennessee

In Tennessee, qualified mental health professionals (QMHPs)– or Master's level and above professionals – are eligible to conduct evaluations.[10] All evaluators must, however, be embedded in a crisis response provider for the state, and they must go through a certification process. Tennessee does allow for physicians or psychologists not embedded in a crisis response provider to conduct evaluations if the evaluator does not arrive to conduct an evaluation within two hours of being called.

In Tennessee, as in many other states, a second evaluation of the individual is required to occur at the admitting facility, where the state tries to incentivize rescinding the order for involuntary commitment when clinically appropriate. Under the state's "disinterested professional" clause, the person conducting the evaluation cannot be employed by the admitting facility.[11]

Oregon

Evaluators in Oregon must also be a QMHP (meeting the qualifications in Oregon to be a QMHP), which they define as psychiatrists, physicians, or individuals with graduate degrees in psychology, social work, psychiatric nursing, or another mental-health related field. All evaluators, with the exception of psychiatrists, must be associated with a community mental health center in the state, designed to help ensure continuity of care and referral to appropriate follow-up services for individuals. All evaluators, with the exception of psychiatrists, must receive certification by the state of Oregon which includes training in the evaluation process, relevant Oregon statute, and establishing "clear and convincing evidence for mental disorder".[12]

North Carolina

North Carolina law, similar to Tennessee, requires in statute a second evaluation to be conducted at the admitting facility. For the first evaluation, evaluators must be certified by the state through an Area Health Education Center, which offer curriculums for health professionals in the state.[13] The first three evaluations a new evaluator conducts must be certified by a physician or eligible psychologist. Licensed mental health professionals who are eligible to become evaluators include licensed clinical social workers, licensed clinical addictions specialists. North Carolina recently added eligibility for Master's level or higher nurse practitioners, physician's assistants, and licensed clinical mental health counselors.

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[9] State Standards for Initiating Involuntary Treatment. Treatment Advocacy Center. (July 2018)

[10] The term QMHP is used in multiple states to refer to varying levels of educational attainment. More information about QMHPs in Virginia can be found through the Department of Health Professions at https://www.dhp.virginia.gov/counseling/counseling_QMHP.htm.

[11] TN Code 33-6-404. Certificate of need for emergency treatment and transportation. https://www.tn.gov/behavioral-health/need-help/training/mpa-refresher-course.html

[12] OR Rev Stat § 426.232 (2017), https://www.oregon.gov/oha/HSD/AMH-LC/Pages/CC.aspx

[13] What AHECs Do. National AHEC Organization. Available at: https://www.nationalahec.org/index.php/what-we-do/what-ahecs-do

Soon North Carolina plans to add licensed marriage and family therapists to the list of eligible professionals.[14]

Virginia's CPSC requirements are largely similar to many other states, utilizing a single evaluator system prior to temporary detention. CSB psychiatrists may become certified CPSCs, however this is not widely pursued. Expansion to different mental health disciplines in other states has typically led to discussions related to appropriate qualifications, credentials, and ensuring human rights. Those topics have been equally considered in Virginia, as well as the added consideration of how expansion of who can conduct preadmission screening evaluations would impact the state hospitals given Virginia's unique "bed of last resort" policy. In other states, the state mental health hospitals have limited admission criteria and serve fewer civilly committed individuals.

Past Studies of the Preadmission Screening Process in Virginia

The process for conducting preadmission screenings in Virginia has been studied in recent years. In 2014, DBHDS conducted an assessment of CPSC qualifications, training, and oversight. The report concluded that the qualifications, training, and oversight of CPSCs should be strengthened via an enhanced certification program, standards of supervision, a standardized orientation, and enhancing ongoing training requirements, which were implemented following the report.[15]

In 2015, DBHDS conducted a review of Virginia's practice of conducting emergency evaluations, which analyzed CPSC response times through a CSB survey. The results, most recently updated in 2016, found that 93 percent of preadmission screenings began within two hours. Delays in initiating evaluations were determined to be primarily due to multiple simultaneous requests being received by the CSB. The 2015 workgroup made the following five recommendations to improve the performance of the emergency evaluation system:

- Further examine response times through an additional survey, obtaining explanatory information for longer response times, and a review of CSB service models
- Review and update the preadmission screening form to determine if it could be reduced in length without sacrificing quality, explore the possible use of an electronic form, and consider allowing ER physicians to agree or disagree with the disposition on the form. The current prescreening form was developed out of this recommendation.
- Create a viable alternative to shared responsibility
- Examine training options for additional CPSCs
- Review requiring magistrates to accept telephone testimony of emergency room physicians[16]

Most recently, in 2019, the SB1488 workgroup reported on recommendations to address the high census at Virginia's state mental health hospitals. One of the recommendations included permitting licensed mental health professionals and other qualified clinicians outside of CSBs to conduct preadmission screening evaluations. Several workgroup members noted that such a change would be complex, impacting multiple other process and could possibly lead to an inadvertent increase in hospital admissions. The current legislative workgroup was developed as a result.

Workgroup Findings

Due to the COVID-19 pandemic, the TDO Evaluator (HB 1699/SB 768) Workgroup met via video conference three times between July and September of 2020. Stakeholders consisted of representatives

[14] Source: § 122C-263. Duties of law enforcement officer; first examination. https://www.ncdhhs.gov/ivc
[15] https://rga.lis.virginia.gov/Published/2014/SD9/PDF
[16] A follow-up review of Virginia's practice of conducting emergency evaluations for individuals subject to involuntary civil admission

from Virginia's CSBs, private hospitals, law enforcement, mental health advocates, and other stakeholder areas. A full list of stakeholders is available in Appendix A. Prior to the first workgroup meeting in July, workgroup participants were provided a survey to which thirteen individuals responded. The individuals represented nine organizations or associations. The survey asked respondents to share their thoughts and concerns around who can conduct preadmission screenings in Virginia as well as gauge the potential impact of expanding categories of professionals who can conduct preadmission screenings, and to identify the key issues the workgroup should consider. The survey was not intended to provide a representative understanding of the ways to expand CPSCs in Virginia nor the benefits and challenges associated with expanding CPSCs, rather, the survey results then served to facilitate broad discussion during the workgroup meetings.

Impact of expanding the categories of TDO evaluators

The most highly rated areas in which participants thought expanding the categories of CPSCs would likely have an impact included (Figure 1):

- Expediting the preadmission screening process
- Building workforce capacity
- Improving continuity of care
- Expanding access to evaluators for re-assessment prior to hospitalization

The majority of the workgroup agreed that including other professionals could speed up the TDO evaluation, but the effect on the overall process would be minimal because it was noted that the most time-consuming aspect of the preadmission screening process was not the actual evaluation but the search for an available bed. While enhancements to the bed registry are needed to continue to improve its usefulness in speeding the search for a bed, it was noted that if the evaluators are expanded, CSB workers may be able to spend more time in diversion strategies such as crisis intervention, warm handoffs to community providers, and emergency room avoidance, especially taking into consideration the proposed expansion for mobile crisis services. [17]

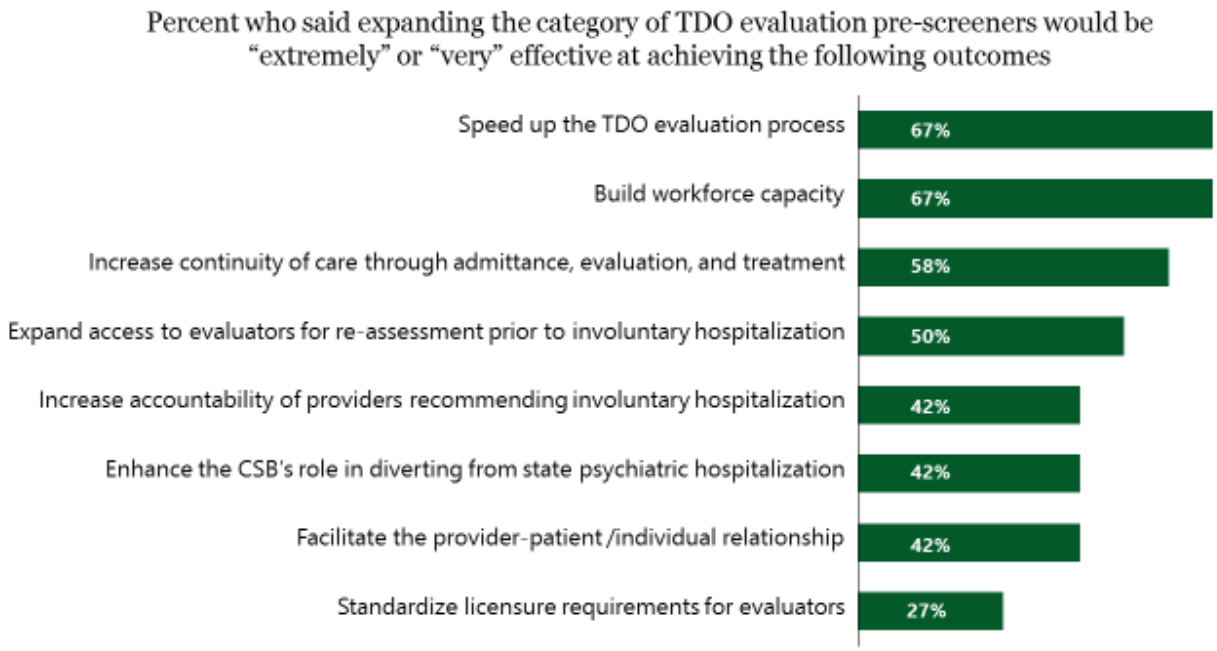
Regarding continuity of care, it was noted that individuals presenting to the emergency department who have already been evaluated by an emergency room physician would benefit by not having to provide their mental health history again and experience another evaluation by a different evaluator, especially if the evaluation required the sharing of sensitive information such as trauma. Hospital participants described that appropriate and comprehensive care in the emergency room is conducted through a team-based approach, utilizing physicians, social workers, nurses, care coordinators, and other staff who can conduct the work that a single CSB evaluator does. Other participants conversely shared that CPSCs spend more time with an individual in crisis, and that in the high-paced environment of the emergency department, physicians often do not spend that length of time on evaluation and crisis management. Therefore, the patient experience and efforts toward diversion from inpatient hospitalization may be better when conducted by a CSB evaluator.

Although there is no requirement in the Virginia Code for a CPSC to conduct re-assessments of individuals under an ECO, it was noted that reassessments are often needed because the clinical picture of an individual can change over an eight hour period, such as for individuals who are intoxicated or convert to a voluntary status. If the law is amended to expand the professionals who can conduct preadmission screenings, physicians and LMHPs in emergency rooms would be able to conduct reassessments when needed. Workforce capacity across the system of care is a well-known need, and while the CSBs are currently able to meet the demand of preadmission screenings in a timely manner, the work of conducting

[17] Such enhancements are being considered by the HB1452/SB739 workgroup

such screenings could be expanded to be shared with other trained individuals who would be accountable as well.

Figure 1: Expected Impact of Expanding Categories of CPSCs



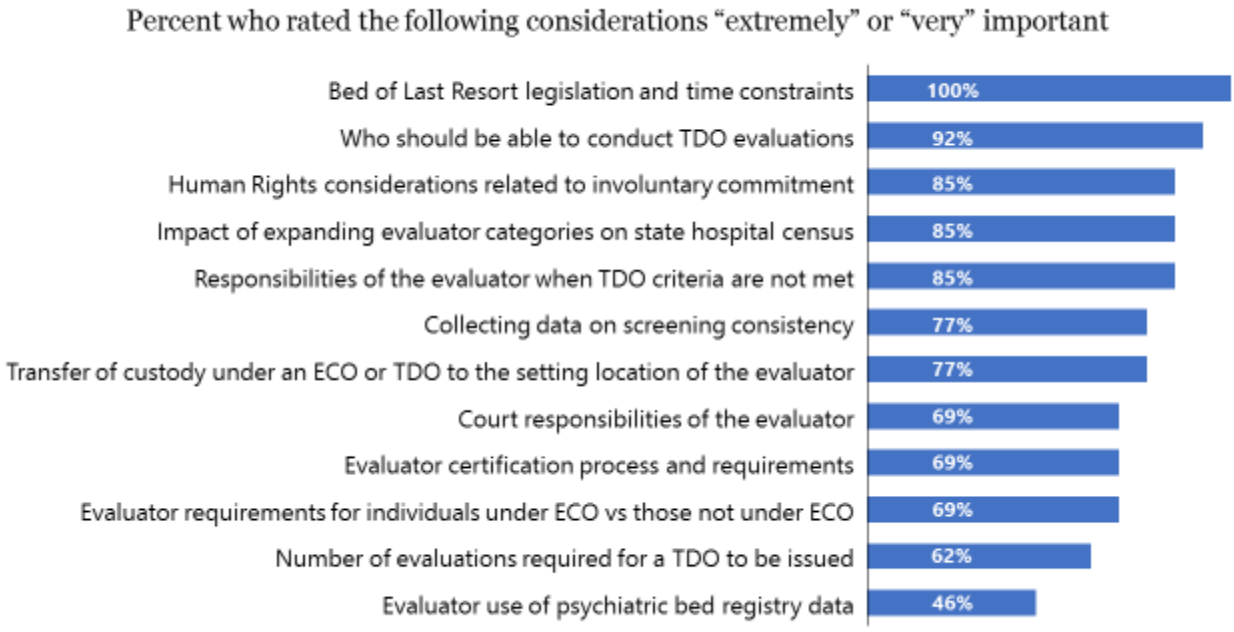
Key considerations for developing a plan to expand professional categories of TDO evaluators

Expanding categories of professionals who may conduct preadmission screenings has been a repeated point of discussion over many years, and, rightfully, there have been valid concerns when there are potential changes to any aspect of the involuntary commitment process. The workgroup specified these through the survey and the concerns were discussed extensively in the workgroup.

When asked to rate the importance of key considerations, the most highly rated considerations (Figure 2), in addition to who should be able to conduct preadmission screenings, included:

- "Bed of Last Resort" law and time constraints
- Human rights considerations related to involuntary commitment and the individual's experience
- The potential impact on the state hospital census
- Responsibilities of the evaluator when TDO criteria are not met

Figure 2: Key Considerations for the Workgroup



These key considerations highlight the responsibilities of the CPSC in the legal aspects of the TDO process, as well as the concern of how expanding who can conduct preadmission screenings could impact the state hospital census. In the section earlier in the report titled *Responsibilities of Emergency Services CPSCs*, it is noted that there are several sections of Virginia Code that mandate certain actions be taken. Therefore having TDO evaluators exist across the public and private sectors poses significant process challenges in overall system coordination. There was no agreement among workgroup participants about who should complete TDO paperwork (particularly due to the length of the current preadmission screening form) or participate in the TDO hearing. Likewise, there was no agreement about whether or not ECO custody should be transferred from law enforcement to hospitals and back to law enforcement if a person is then subjected to a TDO, or how to ensure accountability in the "bed of last resort" policy and associated time requirements. While coordination would likely occur, generally it was felt that the prescreening evaluator's organization, whether it is a hospital or a CSB, should be accountable for the entire process from start to finish, and that there should be safeguards to protect from conflicts of interest.

Some suggested that the TDO paperwork should be reviewed and shortened without compromising comprehensiveness, and that a statewide quality assurance and improvement system and standardized training is needed. However, CSB participants who utilize the current form did not suggest revision, noting it was recently developed by legal and clinical experts and revision is unnecessary. There is currently no established quality and data management system established for the ECO/TDO process, and some participants noted that standardized quality expectations and data management may be best accomplished through a contracted entity that can access information across the public-private system.

Most importantly, all participants recognized the state hospital system crisis, and while there is no desire to increase state hospital admissions through the expansion of evaluators outside of the public system and current process, it was noted that this could be an unintended consequence of a significant change to the current process, particularly without ample planning and implementation time. Constraints on access greatly influence involuntary commitment practice as it may serve as a way to prioritize intensive mental

health services for individuals who would have difficulty accessing services otherwise.[18] All participants agreed that Virginia should continue to build out a comprehensive continuum of high quality, accessible services through STEP-VA and Medicaid Behavioral Health Enhancement.

Recommendations

Six broad recommendations emerged as a result of the discussions during the work group meetings. They are summarized here:

Recommendation #1: Prioritize and continue the development of a comprehensive system of care, through STEP-VA and the Medicaid Behavioral Health Enhancement in Virginia. This continuum of care across the lifespan should focus on high quality, evidence-based community services to prevent the need for more costly acute care and reduce overreliance on institutional care. There is a critical shortage of licensed behavioral health workforce and all professionals with the skills, training, and knowledge in various aspects of the evaluation and treatment of mental illness should be employed to their fullest potential, work collaboratively with each other, and optimize resources across the system. While workforce shortages are an issue regardless of payor source, they are magnified in the Medicaid population because many licensed health professionals accept few or no Medicaid members due to low Medicaid reimbursement rates. Thus Medicaid Behavioral Health Enhancement is a critical strategy to build workforce capacity to deliver high quality services, particularly those to prevent the need for mostly costly acute care and reduce overreliance on institutional care.

Recommendation #2: Integrate principles of continuous quality improvement to ensure that any implemented system changes are standardized, monitored, and periodically revised as needed. Quality management processes should be included in a plan for any system changes. Quality oversight across a public and private system may benefit from a broad data management and integrated care coordination process and should include the healthcare triple aim:

- Improve the patient experience: regardless of who conducts the preadmission screening, in order to help ease any resulting trauma, requirements should be considered to have peer support specialists present during the evaluation.
- Improve health outcomes: optimizing and expanding the behavioral health workforce facilitates people accessing other needed services.
- Improve cost efficiency: promote emergency room avoidance and diversion from inpatient services when appropriate.

Recommendation #3: Current processes, such as completion of TDO-related paperwork and bed searches, are lengthy and take away from time spent with an individual in crisis in need of support. Therefore, any changes to who may prescreen should be paired with efforts to streamline the administrative elements of the process for all prescreeners.

Recommendation #4: Investment in an enhanced bed registry tool, which was considered by the HB1453/SB739 workgroup, is critical to expediting the bed search process as well as facilitating a potential handoff from private provider to CSB if a private provider were conducting the initial preadmission screening or even requesting a preadmission screening.[19] This would also lower the threshold for information the CSB must provide over the phone to hospitals while in search of a bed, as

[18] Substance Abuse and Mental Health Services Administration: Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice. Rockville, MD: Office of the Chief Medical Officer, Substance Abuse and Mental Health Services Administration, 2019.
[19] RD513 - Acute Psychiatric Bed Registry Workgroup Report – November 6, 2020. Available at: https://rga.lis.virginia.gov/Published/2020/RD513

information could be securely uploaded into the registry and shared with inpatient facilities with available beds.

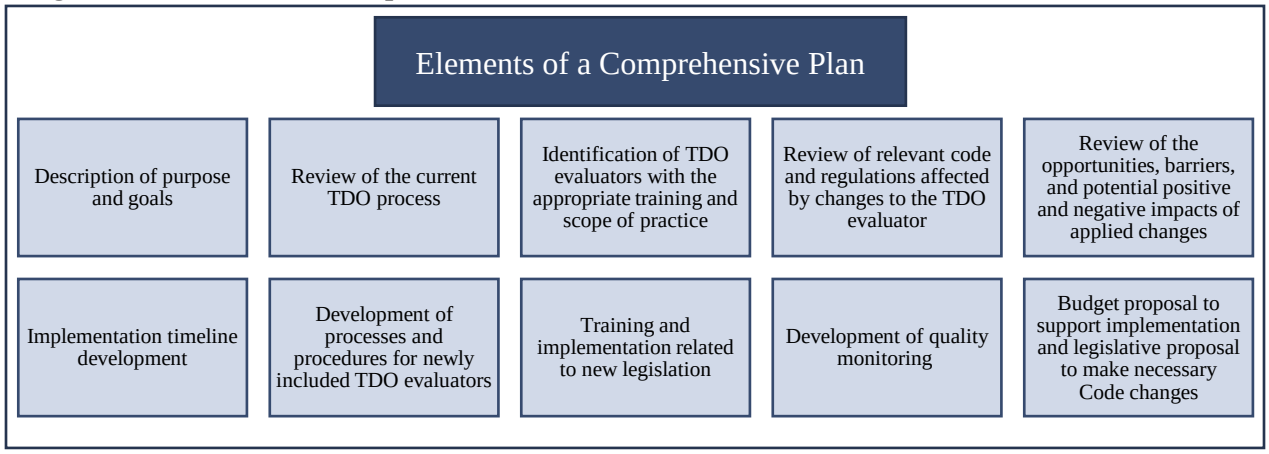
Recommendation #5: Changes to current processes must give special consideration to the impact on inpatient psychiatric bed capacity, especially the impact to the state mental health hospitals given their frequent operation at or above capacity. Evaluators should demonstrate due diligence in diverting individuals from involuntary inpatient treatment and towards least restrictive settings whenever appropriate.

Recommendation #6: Conflict of interest on the part of the evaluator should be avoided at all times.

Comprehensive Plans for Expanding TDO Evaluators

Figure 3 highlights overall components in the comprehensive plan for expanding TDO evaluators. These components were thoughtfully compiled by the workgroup to ensure that it is clear that the pathway for change consists of a series of interrelated steps rather than something that can be changed quickly. Consideration of various aspects of the Virginia Code, direct and indirect financial impact, and oversight and accountability are among the key components. With these elements in mind, and the extensive contribution from the workgroup participants, DBHDS developed and presented two plans or pathways for the workgroup's consideration. Each of the plans are described below and include a brief summary of the discussion regarding opportunities, barriers, and the potential positive and negative impact of any changes. The plans also contain specific recommendations for legislative or budget actions necessary to implement the plan.

Figure 3: Elements of a Comprehensive Plan



Pathway 1: New Categories of TDO Evaluators within the CSB System

Description of purpose and goals. Under this proposal, preadmission screening evaluators would remain in the public sector within the CSB system. The goal for this pathway is to optimize the mental health workforce within the CSB system. This pathway would aim to broaden the eligibility of qualified mental health professionals within the CSBs (either employed or contracted) who would be able to serve as TDO evaluators.

Identification of TDO evaluators with the appropriate training and scope of practice. CSB employees or contracted employees with a minimum educational requirement of having obtained a Master's level degree within a related field and a specified amount of relevant clinical experience would be eligible to become CPSCs. This would include certain designated Qualified Mental Health Professionals (QMHP)

who are registered with the Board of Counseling, provided they have accumulated a specified amount of experience.[20] QMHPs are not licensed mental health professionals; rather they provide collaborative mental health services for adults or children. While certain QMHPs may already be eligible to be CPSCs, this pathway could broaden the eligibility for additional QMHPs to serve as TDO evaluators.

Review of the opportunities, barriers, and potential positive and negative impacts of applied changes. This pathway for expansion would be a minimally disruptive approach to expand qualified CPSCs as the process to conduct preadmission screening evaluations would remain the same and simply allow for additional qualified professionals within the CSB system to conduct preadmission screening evaluations. Training, oversight, and certification would remain largely the same; DBHDS would require time to work with stakeholders and examine the need for modifications to specific areas such as training or certification requirements as well as the specific Master's degrees and years of experience necessary for CPSC eligibility. In terms of impact of this expansion pathway on the overall system, the bed search is the most time-consuming part of the preadmission screening process, and while the work group generally thought that expanding the categories of TDO evaluators within the CSB system would not significantly cut down on the total time of the TDO process, it might allow for bed search responsibilities to be shared and therefore could help alleviate that challenge. It is unclear without further study if Virginia has sufficient workforce with experience requirements to meet the goals of this particular expansion pathway, and it is unknown without further study how many new preadmission screening evaluators could potentially be added under this pathway. Also, it should be noted that the scope of a QMHP in Virginia does not include diagnosing, a required element of pre-screening, with certain exceptions for trainees working towards licensure; therefore potential positive impacts of this applied change could be limited.

***Review of relevant law and regulations affected by this proposal*.** This plan does not propose any changes to the current preadmission screening process. The same certification process would be required. To broaden the eligibility for QMHPs to be able to conduct preadmission screenings, DBHDS would be required to update the policy and procedural document, Certification of Preadmission Screening Clinicians.

Budget proposal to support implementation and legislative proposal to make necessary Code changes. Changes to the Virginia Code are not needed to expand CPSCs within the CSB system. The current definition at §37.2-809(A) of a "Designee of the local community services board" would be expanded through DBHDS policies and the certification program. There are no known regulations that would be affected by the proposed change.

Potential fiscal impacts associated with this pathway may include:

- State level: Implementation of a quality management process including human resources and a data management system to obtain valid and reliable data to implement a continuous quality improvement process
- Local level: CSBs may recruit and employ additional personnel to help fulfill the expanded role of TDO evaluators or further support TDO evaluators in the administrative aspects of the process. Additionally, if there is a quality management process, CSBs may need additional resources to support the quality management system needs.

Implementation timeline development. Implementing the changes addressed in this expansion pathway would require about an 8-10 month planning timeline to accomplish the following:

[20] More information about QMHPs in Virginia can be found through the Department of Health Professions at https://www.dhp.virginia.gov/counseling/counseling_QMHP.htm.

- *Development of processes and procedures for newly included TDO evaluators* - Processes and procedures for newly included TDO evaluators under this expansion pathway include enabling the expanded evaluator group to take part in the established training and certification program.
- *Training and implementation* - Training and certification requirements would be updated by DBHDS and disseminated to the CSBs
- *Development of quality monitoring* - Implementation of a quality oversight process that includes participation of stakeholders across multiple systems should be established. The main challenges for this are related to obtaining timely, valid, and reliable data, as there is no current single data management system that collects all the relevant data needed.

Pathway 2: Expand the Categories of Evaluators to include Physicians and LMHPs in Emergency Rooms

Description of purpose and goals. This pathway would allow physicians and other licensed mental health professionals (LMHPs) who work in emergency rooms to serve as preadmission screening evaluators. This pathway aims to further optimize the roles of licensed professionals, and the goal would be to expand the number of mental health professionals who can conduct preadmission screenings outside of the existing CSB system. When a person in an emergency department is deemed to require a preadmission screening, a physician or LMHP employed or contracted by the hospital would be able to conduct the preadmission screening, which is not currently permitted.

Identification of TDO evaluators with the appropriate training and scope of practice. Physicians and LMHPs have established clinical expertise by nature of their education and licensure attainment through the relevant health professions board of the Department of Health Professions. These professionals who then work in an emergency room setting gain additional clinical experience with individuals who present in a mental health crisis. In general, the workgroup believed that physicians and LMHPs would not require additional training on the clinical determination of whether an individual meets criteria for a temporary detention order. It is recommended that a measure of competency, skills, and knowledge be required in order to perform preadmission screenings and that physicians and LMHPs working in emergency rooms have a minimum level of experience with individuals experiencing mental health crises.

Review of the opportunities, barriers, and potential positive and negative impacts of applied changes. The workgroup identified several opportunities, barriers, and potential positive and negative impacts of this proposed pathway. In general, the opportunity exists to more effectively utilize a range of mental health professionals at settings where people in psychiatric crisis present in order to streamline the preadmission screening evaluation process. However, it was acknowledged that there would be numerous processes and procedures that would need to be thoroughly developed during the planning and implementation phase (i.e. specific processes related to whether emergency department staff who conduct preadmission screenings would be responsible for disposition of individuals who do not meet TDO criteria and/or accept voluntary admission; would these staff who conduct preadmission screenings attend the commitment hearing or would CSB designees still perform that role; etc.). A potential positive of expanding TDO evaluators to include emergency room physicians and LMHPs is that it may minimize the repeated psychiatric evaluations a person undergoes if there is a single evaluator from the time of presentation through final disposition (whereas currently the person may undergo an evaluation in the emergency room by staff present and then a second evaluation by a CPSC). A potential positive of this pathway is that CPSCs and CSB crisis resources would be able to be better optimized for individuals in crisis to help in avoiding emergency room-based care.

A concern raised was the potential for an unintended increase in TDO admissions to state psychiatric hospitals as evaluators who work in private hospital settings may not be fully aware of all community alternatives to the state psychiatric hospitals. Additionally, there were concerns that if the evaluation was

separated from the bed search process, it could lead to fragmented care or care coordination problems in addition to questions about liability and responsibility.

Finally, some participants raised the question of whether psychiatrists in private, outpatient settings should be able to conduct preadmission screenings. As any move to expand CPSC eligibility outside of the CSB system would be a significant change, this pathway focuses on an expansion limited to the emergency department setting to allow for quality monitoring and measurement of the impact on the state hospital census. Additional pathways for expansion could be reconsidered after sufficient time for quality and census monitoring of this pathway.

Review of relevant code and regulations affected by changes to the TDO evaluator.
Changes to the Virginia Code would be needed to enable non-CSB physicians and licensed mental health professionals to serve as TDO evaluators. These are listed below. There are no known regulations that would be affected by the proposed change. Most of the needed changes to the Virginia Code would be to elements of the prescreening process and the statutory responsibilities that the preadmission screener performs.

- Permitting non-CSB staff to conduct preadmission screening evaluations.
    - Amend 37.2-809.B to permit non-CSB staff to conduct preadmission screening evaluations.

- Preadmission screening report.
    - Currently the Code of Virginia does not specify that the preadmission screening report must be completed to obtain a TDO, so the process of evaluation and the completion of the prescreening report can remain separate. However, documentation of the evaluation is needed and must be included in the preadmission screening report which is required for the commitment hearing. Changes to the Virginia Code would be needed to further examine and accommodate for the emergency room physician or licensed mental health professional completing the TDO evaluation.
    - Further work with stakeholders is required to determine whether the preadmission screening form can be accurately completed by someone who did not conduct the initial screening.

- Ensuring the emergency room evaluator is available for consultation by the magistrate or judge/special justice up to and during the individual's commitment hearing through Virginia Code modifications.

- Other relevant parts of the evaluation process in the Code of Virginia should also be reviewed and amended accordingly, including:
    - Determining an individual's insurance status (37.2-809.G)
    - Changing the facility of temporary detention (37.2-809.E)
    - Informing the petitioner if a person does not meet the criteria for temporary detention and facility communication with the special justice (37.2-809.L)
    - Whom law enforcement should contact when they have someone in emergency custody (37.2-808.J)
    - Contacting the state facility after being notified by law enforcement that someone is in emergency custody and, post-evaluation, contacting the state facility with information on necessary services (37.2-809.1)
    - Completing the preadmission screening report (37.2-816)
    - Recommending and obtaining mandatory outpatient treatment (37.2-817)

Budget proposal to support implementation and legislative proposal to make necessary Virginia Code changes. Resources should be allocated for state oversight, planning, implementation, and monitoring of any changes. The resources should include staffing in DBHDS Central Office for data analysis as well as a position to provide oversight, planning and implementation resources.

Implementation timeline development. Implementation of this pathway for expansion would need to be multi-phase with full implementation occurring over an 18-24 month period. It is recommended that legislation to implement this pathway become effective no sooner than July 1, 2022 to allow time for the onset of new community based services and for a stakeholder group to develop and implement specific processes and procedures to accommodate emergency room physician and LMHPs as preadmission screening evaluators. A multi-phase approach would also allow DBHDS and stakeholders to engage in an iterative process regarding best practices, development and implementation of training requirements, and development and implementation of new processes and procedures to accommodate the broadening of prescreening evaluators. This implementation timeline would allow for:

- *Ongoing development of the continuum of care* - The development of a range of diversion options from inpatient psychiatric admission to be made available (specifically the first six services listed in the Medicaid behavioral health enhancement: comprehensive crisis, partial hospitalization, intensive outpatient programs, assertive community treatment, functional family therapy, and multisystemic therapy).
- *Development of processes and procedures for newly included TDO evaluators* – Due to the substantive changes to the Virginia Code, new policies and procedural documents would need to be established with input from stakeholders to establish training and eligibility requirements and clarity of roles across the public and private systems. Each iterative change may require the development of a related procedural document or training materials
- *Training and implementation* - Under this expansion pathway, it is recommended that a modified training be developed and implemented for physicians and LMHPs who serve as preadmission screening evaluators. This training would not focus on clinical aspects of the TDO evaluation, but also aspects such as community resources, least restrictive options, and any process-specific training requirements. It is critical that there is standardized training and maintenance of TDO evaluator certification across the public and private sectors in the application of the state's mental health laws, which includes a process for notifying and re-training certified TDO evaluators when there are changes to processes or legislation.
- *Development of quality monitoring* - Implementation of a quality oversight process that includes participation of stakeholders across multiple systems should be established. The main challenges for this are related to obtaining timely, valid, and reliable data, as there is no current single data management system that collects data across multiple sectors. This could be optimally achieved through the use of a Quality Improvement Organization that would collect and analyze a standardized set of data regardless of the source, and provide technical assistance as directed by DBHDS and informed by a stakeholder advisory board.

Conclusion

There was no consensus within the workgroup regarding either pathway proposed, and given the robust discussion among the participants and the complex process of involuntary commitment, the path forward is not a straight one. However, a well-informed, transparent, and collaborative plan can pave the way to solutions to the most challenging problems, including here in Virginia. Expanding categories of professionals who are able to conduct preadmission screening evaluations is one solution to a larger problem – a limited mental health workforce. There is an opportunity to optimize and efficiently utilize the existing workforce – and train colleagues within and across systems – to provide high quality, trauma-informed care to any person experiencing a mental health crisis. This must be done in a person-centered

way while also ensuring coordination across multiple systems that are involved when someone is experiencing a psychiatric crisis. The workgroup emphatically agreed that regardless of which pathway may move forward, ample resources and time should be allocated to adapt training and certification requirements, establish quality oversight and other mechanisms to measure the impact of the change, center the guiding principles articulated from SAMHSA, and make adjustments over time so that the best outcomes are achieved for the individual and the overall system of care.

Appendices

Appendix A: Workgroup Representatives

Workgroup Chair: Mira Signer, Chief Deputy Commissioner, Community Services

Workgroup Members

Department of Medical Assistance Services	Brian Campbell
	Laura Reed
Mental Health America - Virginia	Bruce Cruser
National Alliance on Mental Illness - Virginia	Beth Tolley
	Kathy Harkey
Office of the Executive Secretary (advisory capacity only)	Jonathan Green
	Kristi Wright
The Medical Society of Virginia	Mary Malone
	Scott Johnson
The Psychiatric Society of Virginia	James Pickral
VCU Health System	Dr. Harinder Dhindsa
	Karah Gunther
Virginia Association of Community Services Boards	Curt Gleeson
	Jennifer Faison
	Sarah Gray
Virginia Association of Counties	Katie Boyle
Virginia Association of Police Chiefs	Dana Schrad
Virginia College of Emergency Physicians	Aimee Perron-Seibert
	Dr. Bruce Lo
	Dr. Jared Goldberg
Virginia Hospital and Healthcare Association	Cindy Estes
	Jennifer Wicker
	Lisa Castro
Virginia Municipal League	Janet Areson
Virginia Sheriffs' Association	John Jones
VOCAL	Deidre Johnson
Voices for Virginia's Children	Ashley Everett

Other Stakeholders

Senate Finance and Appropriations Committee	Mike Tweedy
House Appropriations Committee	Susan Massart
Division of Legislative Services	Sarah Stanton
	Delegate Aird
	Senator Deeds
	Senator Barker
Office of the Attorney General	Allyson Tysinger

DBHDS Staff:

Alex Harris, Policy and Legislative Affairs Director
Dr. Alexis Aplasca, Chief Clinical Officer
Cari Hennessy, Statistical Methodologist
Heidi Dix, Deputy Commissioner for Quality Assurance and Government Affairs
Mary Begor, Crisis Services Coordinator
Sharon Bonaventura, Regional Crisis Systems Manager
Suzanne Mayo, Director of Community Integration

Appendix B: Pre-admission Screening Form

Available at: http://www.dbhds.virginia.gov/behavioral-health/mental-health-services/protocols-and-procedures